INTERMOUNTAIN Allergy & Asthma

5929 S. Fashion Point Dr. Suite 101, South Ogden, UT 84403 (801) 476-0052 fax (801) 476-0064

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To:_____

Address:_____

I am soon to be or am currently being evaluated by **Joseph R. Anderson, M.D.**

You are hereby authorized to release the following data from my medical records:

- ☐ Evaluation and treatment summary
- ☐ X-Ray report
- ☐ Actual skin test results (copy of testing sheet preferred)
- ☐ Actual formula of treatment extract and injection record
- ☐ Any other consultation reports
- ☐ All medical records on file
- ☐ Other (please specify) _____

PATIENT:

_____ _____ _____ _____
Last Name First Maiden Middle

_____ _____ _____ _____ (___)_____
Street Address City State Zip Phone

Birthdate _____ Approximate Dates Treated _____

Admitting Physician, (if hospitalized) _____

Please send requested information to:

Attn Joseph R. Anderson, MD
Intermountain Allergy & Asthma
5929 S Fashion Point Dr, Suite 101
Ogden, UT 84403

This is a single use authorization that expires upon completion of the request. This authorization may be revoked by sending a written request prior to the expiration event.

_____ _____
(Signature of Patient or Responsible Party) (Witness to Signature)

_____ _____
(Relationship to Patient) (Date)